VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

GENERAL.2
FORM#09
R: 1.15

Agency of Human Services

~General~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Physician NPI: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

Will this medication be billed through the: ☐**pharmacy benefit** or ☐ **medical benefit** (J-code or other code)? **(Please check one)**

Please **check box** if this drug is being provided under the DVHA's 340B Drug program ☐

Administering Provider/Facility if other than Prescriber: (Name):_____ NPI#_____

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1. **Drug Requested:_____Strength/Route/Frequency:_____Length of Therapy:_____**
2. Patients diagnosis for use of this medication:_____
3. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:_____
4. Was patient seen by any other provider for this condition? YES/ NO What specialty? _____
5. Please list preferred medications previously tried and failed for this condition:

Name of medication	Reason for failure	Date
_____	_____	_____
_____	_____	_____

6. Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure	Finding	Date
_____	_____	_____
_____	_____	_____

7. Other Information/ Comments:_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____ Date of request:_____

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